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## WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER WORKERS' COMPENSATION COMPLAINT FORM

Please be advised that any materials, medical records or documents that you provide at any time in connection with your complaint will be shared with the insurance companies, adjusters or agents against whom your complaint is filed, and their counsel. These documents may also be distributed to other parties engaged in your contested case or other matters pending before the Insurance Commissioner, including but not limited to the Office of Judges, the Board of Review, Third Party Administrator staff and other appropriate employees of this agency. Documents other than those that are exempt under the West Virginia Freedom of Information Act may also be released if we receive a request for the records under that Act. By signing the complaint below, you are specifically authorizing the Offices of the Insurance Commissioner of West Virginia to disseminate or distribute to any party or entity described above any private information that you have filed at any time with the Consumer Service Division that relates to your complaint. You further authorize such other distribution of this information as the laws of the United States and the State of West Virginia permit or require.

TOUR NAME:							
EMPLOYER / BUSINESS NAME:		FEIN:					
TYPE OF COMPLAINT (circle one):	CLAIMANT	<b>EMPLOYER</b>	VENDOR	OTHER			
CLAIM / POLICY / VENDOR NUMBER:							
YOUR ADDRESS, CITY, STATE, ZIP:	_						
PHONE NUMBER:	FAX:	E-MAIL ADDRESS:					
INSURANCE COMPANY / TPA NAME_							
SPECIFIC POLICY LANGUAGE IN QUE	STION(if known):						
STATUTORY / RULE PROVISION(S) IN							
REASON FOR COMPLAINT / RELIEF F	REQUESTED: Plea	se describe the facts and	d circumstances which	ch form the basis o			
your complaint. You may attach addition	nal pages if necessa	ry. Please attach copies	of any relevant corr	espondence, policy			
provisions, etc.							
A complaint filed on behalf of a corpor	ration must be sigr	ned by an officer of the	corporation.				
In order for this division to take any agreement to the following:	action on your co	mplaint, you must sign	and date this for	n, indicating you			
I hereby authorize any insurance cor Insurance Commissioner any docum- this complaint, including but not limite	ents, claim-related	data, or other informa	ation necessary for	r consideration of			
Signature:		Date:					
Please complete, sign and date, and re	eturn the original fo	orm and any attachmen	ts to:				
Consumer Service Division		Phone: (304) 558-3	386				
WV Offices of the Insurance Commiss	ioner	Toll-free in WV 1-888-TRY-WVIC					
Post Office Box 50540		Fax: (304) 558-496	5				

IF YOU HAVE ANY QUESTIONS OR PROBLEMS COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT 1-888-TRY-WVIC (1-888-879-9842) AND WE WILL ASSIST YOU.

Internet: www.wvinsurance.gov

Revised 6/08

Charleston, West Virginia 25305-0540